FINAL REPORT

Mental Health and Disability Services Redesign Fiscal Viability Study Committee

February 2014

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Senator David Johnson
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Contents:

AUTHORIZATION AND APPOINTMENT

The Legislative Council continued this committee from the 2012 Interim with a new charge. In addition to monitoring implementation of the mental health and disability services redesign and receiving reports from stakeholder groups engaged in implementation of the redesign, the study committee shall propose a permanent approach for state, county, and regional financing of the redesign and identify potential cost savings and service improvements that may be realized by working with community-based corrections services and other programs and services that address common needs or populations (2013 Iowa Acts, SF 452, §184). The study committee shall also study the provisions for implementing mental health and disability services Medicaid offset amounts and repayments by counties relating to the Iowa Health and Wellness Plan. The study committee shall consider the potential effects of the repayment provisions on the ability of the mental health and disability services regions to adequately fund the initial core services and additional core services and to make recommendations to address funding insufficiencies (2013 Iowa Acts, SF 446, §181).

I. Meetings

The study committee was authorized for two meetings which were held on October 22, 2013, and December 17, 2013.

II. October 22, 2013, Meeting

Mental Health and Disabilities Workforce Workgroup. Dr. Mariannette Miller-Meeks, Director of Public Health (IDPH), presented draft recommendations from the workgroup which began meeting in 2012 and is required to submit a final report by December 16, 2013. The recommendations include the following: improve the mental health and disabilities training of primary care doctors and other primary care providers; develop a systems approach and incent the use of a team to improve treatment services, monitoring, and case management of those with mental illness or with co-occurring mental illness or substance use disorders; review licensing and credentialing eligibility criteria; plan immediately for provider service needs over the next 20 years; and identify and implement strategies to fix system problems that inhibit the production of service providers. There was significant discussion from members concerning the system needs for mid-level and unregulated service providers in addition to licensed primary care professionals, and regarding the role of higher education and training requirements for various professionals.

Historical Discussion. Mr. John Pollak, Legal Services Division, and Mr. Jess Benson, Fiscal Services Division, Legislative Services Agency (LSA), provided historical and funding information on the broad policy changes made by the General Assembly during the past 20 years, leading to the most recent redesign enacted in 2012. From a financial standpoint, the transfer from the counties to the state of the responsibility to pay the nonfederal share of Medicaid program costs for Mental Health and Disability Services (MH/DS) and the end of tax relief and system growth payments to counties has been very significant. The cost of this responsibility for FY 2013-2014 is estimated to exceed $250 million. A significant reason for the increases in Iowa's Medicaid expenditures is that the relative economic health of Iowa compared to other states has resulted in a reduction of nearly 7 percent in the federal share provided to the state for the Medicaid program.

Status of Redesign Panel. This panel consisted of Mr. Rick Shults and Ms. Jean Slaybaugh, Department of Human Services (DHS); Mr. Russell Wood, Administrator, Franklin County, Central Point of Coordination (CPC); Mr. Rod Sullivan, Johnson County Supervisor; Ms. Linda Hinton, Iowa State Association of Counties (ISAC); and Mr. Benson. The panel distributed material and responded to questions concerning the current county groupings to form regions under the redesign, Transition Fund expenditures to maintain service levels in FY 2012-2013, the status of unpaid Medicaid and other bills owed to the state by counties, the listings of services comprising the core services to be implemented during FY 2014-2015 and "core plus" services which may be implemented as funding is made available by the state, the status of the per capita funding to equalize funding between counties, the status of the change in the process to determine government responsibility for an individual's MH/DS funding from an approach based upon legal settlement to residency, and other concerns. The discussion included the following points:

- Jefferson County in southeast Iowa has appealed the DHS decision denying the county's request to be exempted from the requirement to enter a regional service system. The

administrative law judge is expected to issue a decision soon. All other counties have either been approved to participate in a region or for an exemption (Polk County).

- On the issue of counties that have unpaid Medicaid or other unpaid balances owed to the state, the balance of $32.2 million owed at the end of May 2013 has been reduced to $5.8 million.
- A number of counties have not received equalization payments because they did not agree to a payment plan for an unpaid balance. These counties also owe more than they will receive in equalization. Several had requested a quarterly payment plan and the co-chairs asked DHS to be very flexible in working with the counties on payment plans.
- Forty-four counties did not receive any amount of equalization payment because their capped property tax levies are equal to or exceed their total authorized per capita expenditures.
- Concerns were expressed that one of the ideas in redesign is that persons currently receiving services should not lose them. Language in core services rules authorizes persons who are not in the mental health or intellectual disability services populations to continue receiving services, provided funds are available to do so without limiting or reducing core services.
- It was clarified that the current DHS budget proposals for FY 2014-2015 do not include funding to support core or core plus services. Advanced crisis intervention approaches such as the use of mobile crisis teams would be classified as a core plus service and are not required without new funding.
- There is uncertainty as to how the new Iowa Health and Wellness Plan will impact the regional system and DHS believes counties are best situated to estimate the impact. There were many questions regarding how DHS will calculate the effect of this impact on a regional system as these calculations are to be used in the coming years to require counties to pay back a portion to the state or reduce property taxes (known as a clawback provision). It was suggested that the clawback should be changed, delayed, or eliminated until more is known about the effect on services.
- With the change from legal settlement to residency, adjustments may be needed to address the status of children, out-of-state persons who present for services, services provided in the dual diagnosis program at Mount Pleasant State Mental Health Institute, the status of homeless persons, and the attraction of new residents to “service rich” counties.
- Implementation and funding of a subacute level of care continues to be a significant need. Rules are being developed in a manner so that the services will meet requirements for Medicaid funding.
- Policymakers need better data to make decisions.
- Data on brain injury services was provided showing that over 800 persons are on the state waiting list for the Medicaid brain injury services waiver and have been on the list for more than 18 months. Supplemental funding was requested for the 2014 Legislative Session to address this waiting list. Several suggestions were made to strengthen language for the regional system to provide services to persons with brain injury and to persons with a developmental disability other than intellectual disability.

- It was suggested that since the county-based MH/DS system has been under significant stress with major annual changes, the system be allowed time to adjust to the existing changes before new major changes are added. It was also noted that the statutory budget requirements provide for county budgets to be finalized by March, far ahead of when it is known what the state budget will be.

Integration with Medicaid. This panel included Ms. Jennifer Vermeer, DHS Medicaid Director; Ms. Maria Montanaro, CEO, Magellan Behavioral Health of Iowa; Mr. Jim Rixner, Executive Director, Siouxland Mental Health Center; Mr. Lynn Ferrell, Executive Director, Polk County Health Services; Ms. Hinton; and Mr. Shults. The panel focused on new health coverage options being implemented as the Iowa Health and Wellness Plan under the federal Affordable Care Act, which expands and coordinates health coverage of low-income persons through the Medicaid program, and on the phase-in under Medicaid of integrated health homes for children with serious emotional disturbances and adults with mental illness by the managed care contractor, Magellan. The discussion included the following points:

- One chart compared benefits under the traditional Medicaid program with the coverage provided under the new Iowa Health and Wellness Plan for individuals with income at or below 138 percent (133 percent with a 5 percent disregard) of the federal poverty level (FPL). Before the federal expansion, most individuals at such income level would only have been eligible for Medicaid, if children were in the family. Under the overall approach, individuals with an income below 138 percent of FPL with various serious conditions who are determined to be medically exempt will be eligible for benefits under the traditional Medicaid program. Under federal requirements, the medically exempt status is referred to as "medically frail" and, among other health conditions, applies to persons with various serious mental health conditions, intellectual or developmental disabilities, or substance use disorders. A scoring system is applied to determine if the condition is serious enough to justify the exemption.
- Iowa Medicaid is implementing strategies to identify medically exempt individuals at enrollment, by referral, and through retrospective claims analysis.
- Concerns were raised about insurance copayment requirements creating a barrier to services. However, copayments are not required under the Iowa Health and Wellness Plan for the services of concern. Insurance regulation should determine whether insurance practices for credentialing service providers create barriers to providing coverage under the private health insurance plans.
- Iowa Medicaid is automatically enrolling the 63,000 persons who are currently enrolled in the IowaCare Program that is being replaced by the new plan. Overall, premiums are waived in the first year of the program, and after that are waived if a person completes specified healthy behaviors in the previous year. Individuals who are subject to premiums can also claim a hardship exemption similar to the one under IowaCare.
- Phase 1 of implementation of the integrated health home approach began in several major cities on July 1, phase 2 will cover other areas in spring 2014, and phase 3 will cover the rest of the state beginning July 1, 2014. The approach uses a team of care coordinators and peer support specialists led by a nurse care coordinator.

- There is a need for adequate administrative support of teams. The enhanced level of support from the hospitals as part of the health home approach implemented in Sioux City has enabled the hiring of a new psychiatrist, and early outcome data from pilot projects indicates reductions in the usage of the acute level of treatment.
- A county representative offered a number of questions about how low-income persons will engage with the new Iowa Health and Wellness Plan and the potential effects on regional MH/DS, initial performance issues with implementation of the integrated health homes, and limitations on county access to service information on common clients when the state assumed payment responsibility for the Medicaid services provided to those clients.

Residential Care Facilities (RCFs) and Work Activity Programs. This panel consisted of Mr. Dan Strellner, Abbe Center, Cedar Rapids, Mr. Terry Johnson, CEO, Genesis Development, Mr. John Severtson, CEO, Opportunity Village, Clear Lake, Mr. Barry Whitsell, CEO, Village Northwest Unlimited, Ms. Lynn Bopes, CPC, Jackson County, Ms. Sharon Nieman, CPC, Plymouth County, Ms. Shelly Chandler, Iowa Association of Community Providers (IACP), Ms. Hinton, and Mr. Shults. Panel discussion included the following:

- RCFs with more than 16 beds generally do not qualify for coverage under the Medicaid program and neither do sheltered work programs. At present, there is a lot of pressure for both services to be modified to qualify for Medicaid. Providers need time and assistance with capital funding to convert or develop residential settings that qualify for support under Medicaid. Presenters provided a number of examples of the costs associated with such conversions or developments.
- Providers noted that persons with mental illness or a developmental disability often have different residential needs and are eligible for different funding streams so that thoughtful, long-term planning is needed to match funding streams with needs.
- As for work activity, especially sheltered work, it was noted that these services are not prohibited for coverage under the regional system. However, some panelists advocated for including these services as specific core services so they are not crowded out by other core services and provided specific examples of this effect. There was much discussion regarding the value of work in providing meaning and purpose to persons' lives.
- Other panelists noted the positive effects of recent efforts by the Vocational Rehabilitation Division of the Department of Education in realigning incentives for providers of work activity programs to MH/DS populations.

Public Comment. Individual commenters offered a new approach to identifying mental illnesses, emphasized the importance of more than 30,000 workers who do not have licenses or certifications but provide necessary MH/DS, deplored the effects of redesign in some areas in cutting or reducing services, and supported moving ahead with redesign but ensuring the adequacy of funding and services.

III. December 17, 2013, Meeting

Mental Health and Substance-related Disorders. The panel members included Mr. Shults, MH/DS Division Adminstrator, DHS; Ms. Kathy Stone, Director, Division of Behavioral Health,

IDPH; Mr. Ferrell, Executive Director, Polk County Health Services; Mr. Patrick Schmitz, Executive Director, Plains Area Mental Health Center, LeMars; and Mr. Chris Hoffman, Executive Director, Pathways Behavioral Services, Waterloo.

Ms. Stone provided program and usage information concerning the substance-related disorder treatment services offered through IDPH by contract with Magellan Behavioral Health of Iowa to low-income Iowans and the department's participation in the MH/DS redesign. Approximately 23,000 Iowans receive services, estimated to be 11-12 percent of those in need of the services. Mr. Ferrell discussed the training received by the regions (Polk and other counties) and service providers on how to deal with persons with multi-occurring disorders. He cautioned that the culture change needed for effective treatment of those with multi-occurring disorders can take a long period of time to successfully implement. Mr. Schmitz and Mr. Hoffman both discussed the training and work committed to implementing a "no wrong door" approach so that persons with multi-occurring conditions can receive the assistance needed. Several presenters emphasized the need for the systems to stabilize from the changes in recent years. It was noted that state institutions are making similar efforts to address multi-occurring conditions.

Discussion focused on how the Iowa Health and Wellness Plan will provide coverage of MH/DS and substance-related disorder services, concerns that the private insurers under the plan will not provide reimbursement for services comparable to the public services, an explanation of how high-need persons can receive additional services under the plan by being deemed "medically exempt" and receive Medicaid coverage rather than private insurance, concerns that service regions for MH/DS and substance-related disorders are not well aligned, how separate federal funding streams are distributed based on the specific disorders but can be combined to provide services at the local level, and the urgent need to fund substance detoxification and crisis destabilization.

Children's Workgroup Report. Mr. Charles Palmer, Director of DHS, and Mr. Jim Ernst, President of Four Oaks, a statewide child welfare services provider headquartered in Cedar Rapids, presented the children's workgroup report. The workgroup met annually from 2011-2013 and submitted a report each year. This year's report included the following recommendations:

- Establish an Iowa Children's Interagency Coordinating Council, either through executive order or preferably through statute, consisting of the directors or designees of these state entities: human services, public health, education, human rights, early childhood Iowa, insurance division, and judicial branch.
- Establish a 15-member Iowa Children's Advisory Council, either through executive order or preferably through statute, consisting of stakeholders to work in partnership with and advise the coordinating council.
- Consolidate redundant children's advisory bodies that interact with the children's MH system. The coordinating council should be charged to conduct an analysis to identify the redundant bodies, and the coordinating council, or its individual members, should take necessary actions to consolidate or modify those bodies identified or recommend statutory changes.

- Identify a minimum set of core services that should be available to all youth. These core service domains were identified as: prevention, early identification, and early intervention; behavioral health treatment, recovery supports, and community-based flexible supports.
- Convene an assessment task force to make recommendations about adoption of standardized functional assessment tools.

Some committee members expressed concern that the recommendations once again rely on creation of additional study bodies, likened the state-level body to the child welfare funding decategorization projects operated at the local level, expressed concern that the funding needs for new approaches are not addressed, and queried about meeting special needs such as intellectual or other developmental disabilities.

County Ending Balances and Expenditures for FY 2012-2013. This panel was composed of Mr. Shults; Supervisor Linda Langston, Linn County; Mr. Wood; Ms. Hinton; and Mr. Benson. This panel discussed spreadsheets and financial information. Much of the discussion focused on explaining the data and how it is difficult to compare data when county responsibilities were dramatically changed in separate years. It was noted that the counties' unpaid obligations to the state were approximately $15 million at the close of FY 2012-2013 but are now approximately $4.5 million.

FY 2014-2015 Budgets, County Levy Amount Limits, Equalization Funding, and Medicaid "Clawback". Mr. Pollak joined the panel. He explained how for FY 2013-2014 and FY 2014-2015, county levies for MH/DS will be the smaller of a county's previous net levy dollar amount or a per capita levy amount equal to the product of $47.28 times the county population. Those counties that had a previous net levy dollar amount less than the per capita levy amount receive an equalization payment for the shortfall. The counties that had a previous net levy dollar amount greater than the per capita levy amount had to reduce their levy dollar amount to the per capita levy dollar amount and do not receive any equalization funding. Unless the law is amended, county levy limits will revert at the end of FY 2014-2015 to the previous net dollar amount levies that were replaced by the redesign legislation. Concern was expressed that an equalization funding appropriation has not been enacted for FY 2014-2015 as was done for other line items and was not included in the DHS budget request for the fiscal year.

Eleven counties self-identified from an ISAC survey as having potential financial problems for FY 2013-2014. After following up with the identified counties, DHS eliminated five from the list, and projected a need of approximately $1.1 million. In discussion, members noted that the projected need for those identified assumes a 25 percent fund balance in the succeeding fiscal year and expressed the belief that many more counties will need additional funding to meet that fund balance percentage standard. Part of the need for the identified counties is due to a requirement in the law for counties to repay Medicaid balances from prior years to DHS by June 30, 2014, and could be deferred if a longer payment plan would be authorized by the General Assembly.

Under the Iowa Health and Wellness Plan (IHWP), for each fiscal year, DHS is required to calculate a Medicaid offset (clawback) amount that would have been paid by a county's services fund for non-Medicaid services, but due to persons' enrollment in IHWP, is instead covered by IHWP. A county has a financial responsibility in the succeeding fiscal year for 80 percent of the

clawback amount calculated by DHS for the prior fiscal year. The clawback amount is first charged to any equalization payment due to the county from the state. If the county does not receive an equalization payment or the payment amount is insufficient, the county must address the responsibility or insufficiency by reducing the amount of the MH/DS levy accordingly. The initial amounts calculated by DHS for FY 2013-2014 are required to be certified by October 15, 2014.

During discussion, DHS noted it is still in the process of determining how to calculate the offset amounts, but the amounts are likely to be calculated based on individuals. One panelist questioned whether it is fair to attribute an individual to a county for offset after the first year and whether a county's cost obligation would be limited to the amount of services and costs covered under the service management plan for that county area. Since the county levy dollar amounts are subject to a fixed limit, others questioned whether paying for inflation of the clawback amounts over time should be a state responsibility. Others were concerned that the clawback could detract from the goal under the per capita levy approach and equalization that each county would bring a relatively equal amount to its region, based upon population. The redesign law creates an expectation that the core services will be expanded and new disability service populations will be added as funding becomes available and some expressed concern that the clawback requirement works against this expectation.

Public Comment. Two periods of public comment were available and 11 individuals testified. Much of the testimony related to sheltered workshop (also known as work center) services where certain service providers are authorized to employ workers with disabilities at subminimum wages. Some supported specifically including the service as a core service while others disagreed and advocated other approaches that integrate a person with a disability into a community setting. A number of persons testifying provided written comments that are posted on the committee's webpage.

IV. Recommendations

Recommendations. At the December 17, 2013, meeting, each member of the committee was invited to make recommendations and comments that were compiled by staff, reviewed by the committee members, and approved to be submitted for further review by the General Assembly. The recommendations offered included the following:

1. Consider approaches that increase predictability and lessen the amount of change so that the new regions can develop and stabilize the service system. Provide for early enactment of an appropriation of equalization funding for FY 2014-2015.
2. Consider options to move from the current $47.28 per capita funding approach to a regional formula based upon population.
3. Enhance the local control of MH/DS.
4. Rebase the clawback requirement annually, delay initial implementation of the clawback requirement by one year, and retain any savings in the system.

5. Continue reviewing the levy authority for county funding and the state funding of regional MH/DS to ensure funding is adequate.
6. Ensure counties are able to carry forward adequate fund balances.
7. Ensure that provider reimbursement rates can be set at a level adequate to preserve service stability for consumers, build community capacity, and strengthen the ability of safety net providers (including community mental health centers and substance-related disorder agencies) to grow and offer services that meet the complex needs of individuals served by the MH/DS system.
8. Require state and regional cost settlement reimbursement methodologies to designate the cost of training and education as a direct cost, allowable as a reimbursable expense.
9. Support the training of mental health peer support specialists and family peer support specialists utilizing nationally reviewed and accepted curricula based on proven service delivery models, and support the increased utilization of peer support and family peer support specialists by providing flexibility for part-time workers and opportunities for credentialing and advancement along a career path.
10. Implement incentive programs to train, recruit, and retain professionals and paraprofessionals qualified to deliver high-quality mental health, substance abuse, and disability services.
11. Look for ways to adequately fund supported work and other work opportunities for persons with a disability.
12. Provide support for the residential care facility service level.
13. Provide sufficient funding for prevocational and vocational rehabilitation services so that Iowa can draw the entire available federal match.
14. Consider educating emergency medical services (EMS) providers to provide mobile mental health crisis team services at the local level.
15. Consider earmarking state liquor profits to fund substance detoxification and other needed substance use disorder services.
16. Expand the availability of subacute services and hospitals able to provide a 23-hour hold to stabilize persons in a mental health crisis.
17. Provide for continued meeting of the members of the interim committee to work on issues.
18. Move forward with standardized assessments for children's service.
19. Enhance the MH/DS system capacity for early intervention, including during early childhood.

20. Better define regional "access to services" to mean the services are provided at the local level rather than to mean the services are available somewhere within the region.
21. Work on expanding core services to core plus services and provide eligibility for persons with brain injury or a developmental disability.
22. Consider increasing the bed cap on psychiatric medical institutions for children (PMICs) to accommodate the loss of the Iowa Juvenile Home beds.
23. Expand the postsecondary education options at community colleges and other educational institutions for persons with disabilities.
24. Develop capacity to better identify changes in service populations caused by the shift from legal settlement to residency and other reasons.
25. Enhance the training and development of the workers in the system and provide consistent evaluation tools.
26. Provide for state employment of the judicial branch mental health advocates.

V. Materials Filed With the Legislative Services Agency

The following materials were distributed at or in connection with the 2013 Interim meetings and are filed with the Legislative Services Agency. The materials may be accessed from the "Committee Documents" link on the committee's Internet site:
https://www.legis.iowa.gov/committees/committee?ga=85&session=2&groupID=357

1. Recommendations – December 2013
2. December 17, 2013, Minutes
3. Mental Health and Disabilities Workforce Workgroup Final Report – IDPH
4. Mental Health and Disability Services Redesign Fiscal Viability Study Committee
5. Accounts Receivable List of Amounts Owed by Counties for Medicaid and Other Services – alpha sort – DHS
6. Accounts Receivable List of Amounts Owed by Counties for Medicaid and Other Services – high to low balance sort – DHS
7. Children's Disability Services Workgroup Final Report – DHS – November 2013
8. Clawback Scenarios Graphic – DHS
9. Counties with Possible Funding Issues in FY 2013-2014 – DHS
10. County $47.28 Per Capita Levy Graphic and Listing – LSA Fiscal Services
11. County MH/DS Actual and Budgeted Revenues & Expenditures – FY 2012-2013 – ISAC
12. County MH/DS Budgeted Revenues & Expenditures – FY 2013-2014 – ISAC
13. December 17, 2013, Tentative Agenda
14. Equalization Payment Status Listing for FY 2013-2014 by County – DHS

15. Iowa Association of Community Providers Survey of Service Cuts and Changes in Calendar 2013
16. Iowa Law on County MH/DS Fund Levies, Per Capita Equalization, and Medicaid Offset (Clawback) Amounts – LSA Legal Services Division
17. Iowa Mental Health and Disability Services Commission – 2014 Law Change Recommendations
18. Map of Approved MH/DS Regions as of December 6, 2013 – from DHS
19. Selected Milestones Timeline for Adult DS Service System Redesign – LSA Fiscal Services
20. Substance Use Disorder Treatment Fact Sheet – IDPH
21. Summary of Options for Resolving Accounts Receivable Credits Owed to Counties – DHS
22. Work Activity Services Comments – Iowan Association of People Supporting Employment First (APSE)
23. Work Activity Services Comments – Lois Graettinger (by Senator Johnson)
24. Work Activity Services Comments – Eric Donat, Waterloo
25. Work Activity Services Comments – Janet Sullivan, Parent
26. Work Activity Services Comments – Marcy Davis, Candeo
27. Work Activity Services Comments – Pat Airy, Goodwill of the Heartland
28. Advocate's Guide to Mental Health & Disability Services Redesign – ID – Action
29. Behavioral Health Workforce Recruitment and Retention – National Conference of State Legislatures (NCSL) Memo
30. Iowa Health & Wellness Program – Medically Frail/Exempt Individuals – DHS
31. Integrated Health Homes slides – Magellan Behavioral Care of Iowa
32. Map of Approved MH/DS Regions – Aug 2013 – from DHS
33. Medicaid/Iowa Health & Wellness Plan Benefits Comparison – DHS
34. Mental Health & Disabilities Workforce Workgroup Draft Recommendations – DPH
35. Mental Health & Disability Services State Funding FY 2001-FY 2014 – LSA Fiscal Services
36. Mental Health & Disability Services Redesign Historical Information – LSA Legal Services
37. October 22, 2013, Draft Minutes
38. October 22, 2013, Revised Agenda
39. October 22, 2013, Tentative Agenda
40. Per Capita Equalization & Unpaid Billings Summary as of October 2013 – DHS
41. Regional Core Services – Statute and Rules as of October 2013 – LSA
42. Residential Care Facility Information from Iowa Association of Community Providers

43. Sheltered Work Information from Iowa Association of Community Providers
44. Transition from Legal Settlement to Residency – ISAC
45. Transition Fund for FY 2012-2013 – Key Points – DHS
46. 2013 Final Committee Report – Draft
47. ISAC Analysis and Map – County Funding of Non-Medicaid MH/DS – FY 12
48. ISAC Recommendation on Appropriate Level of County Services Fund Reserves
49. DHS Analysis – County Funding of Non-Medicaid MH/DS FY 13 and Beyond
50. DHS Analysis of County Funding – Appendices 1 and 3-6
51. DHS Analysis of County Funding – Appendix 2 (8.5x14 landscape)
52. Mental Health and Disability Services Redesign Fiscal Viability Study Committee
53. Recommendations of the 2012 Interim Mental Health and Disability Services Redesign Fiscal Viability Study Committee
54. January 11, 2013, Minutes

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